## Dr. Russell Graham Naturopathic Physician

## Medical Intake form – Please fill in

**Date** _____ **Referred by:**_____**Age**_____

**Name**: _____**Birthdate**: _____ **Care card #**_____

**Address**: _____**Tel: (H)**_____

**(W)**_____(**C**)_____**Email**_____

**Contact person and number in case of an emergency**:**Name** _____ **#**_____

**Main Health concerns**:1)_____2)_____
_____
3)_____4)_____

**Current medications**:**1)**_____**2)**_____**3)**_____**4)**_____
_____

**Past medical conditions/ surgeries**:_____

**Family illness history: (mother)**_____(**father**)_____

**Please list any known allergies**:_____

**How many cups a day of**: **1)Coffee**_____ **2) Tea**_____**3) Alcohol**_____**type**_____**4) pop/ cola**_____

**Please check if any of the following areas/symptoms are of a current or recurring concern for you.**

**General**: ___Sleep ___Energy ___ Appetite ___Cravings ___Mood ___Weight ___Motivation___Stress

**Skin and Hair** : ___Itching ___Dry ___Rash ___Sores/recent moles ___Acne ___Hair loss ___Dandruff.

**Ears/Eyes/Nose/throat**: ___Headaches ___Neck pain ___Dizziness ___Earaches ___Ringing ears

___Eye pain ___Vision ___Sinuses ___Nose bleeds ___Jaw/ teeth ___Sore throat ___Facial pain ___Lips

**Cardiovascular**: ___High or low blood pressure ___Irregular heartbeat ___Shortness of breath ___Fainting

___Blood clots ___Swollen feet ___Varicose veins ___Calf pain when walking ____ Dizzy spells/ vertigo.

**Respiratory**: ___Cough ___Bronchitis ___Asthma ___Difficult breathing ___Pneumonia ___Other

**Gastrointestinal**: ___Indigestion ___Rectal gas ___Abdominal bloating ___Belching ___Bad breath ___Constipation ___Nausea ___Diarrhea ___Cramping ___Hemorroids ___Blood in the stool ___Other

**Genito-urinary**: ___Frequent urination ___Urgency to urinate ___Painful urination ___Incontinence ___Decreased flow ___Blood in urine ___Bladder infections ___Kidney stones ___genital sores ___Other

**Gynecology/Pregnancy**: ___Problems with menstrual cycle(too long/ short) ___problems with menses (pain/ flow) ___Painful intercourse ___Vaginal discharge ___Vaginal sores ___Reoccurring yeast infections (past or present) ___Breast lumps. Number of pregnancies____ Births____C-sections____ Miscarriages____ Do you use birth control_____ Type_____ How long_____

**Musculoskeletal**: (area of concern) ___neck ___back ___shoulder ___Hip ___Knee ___elbow ___wrist ___ankle ___foot ___hand ___fingers ___toes ___ body aches ___weakness ___weather/ pressure affects

**Neuropsychological**: ___anxiety ___depression ___anger ___irritable ___mood swings ___memory ___attention difficulties ___problems sleeping ___low energy ___difficulty relaxing.

**Dental**: (please approximate the following). Number of fillings(Silver)_____(Gold)_____,Number of root canals_____. Do you have ongoing problems with your teeth or gums (Yes / No).

**Any other concerns**:_____

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